REIMBURSEMENT FOR: CHILD CARE COST FOR VOLUNTEERS IN SUPPORT OF

FAMILY PROGRAMS

Please print LEGIBLY – Unreadable data may delay payment.

Mail to: Family Programs Office ATTN: FRSA, 2823 W. Main, Rapid City, SD 57702

Reimbursement for time spent in the actual event, training, classroom.

NAME:_____ **DATE:**_____

MAILING ADDRESS:_____

Event Date

DATE:_____ **FOR:**_____
(NUMBER OF CHILDREN IN CHILD CARE)

Event Start Time

TIME IN:_____ **AMOUNT PER HOUR:$2 per hr, per child**

Event End Time

TIME OUT:_____ **TOTAL NUMBER OF HOURS OF EVENT:**_____

TOTAL COST:_____

(Cost per hour X # of children X length of event)

CHILD CARE PROVIDER:_____
(Name of person providing care)

ADDRESS:_____**PHONE:**_____
(Phone and address where care is being given)

ACTIVITY: Child Care_____

APPROVED BY: BRYAN A JACOBSON, STATE FAMILY PROGRAM DIRECTOR
(NAME, TITLE OF APPROVING AUTHORITY)

RECEIVED:$_____

VOLUNTEER SIGNATURE:_____
(Must be signed for reimbursement)

SDNG Form 600-12-4R (1 AUG 97)